



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

AUG 27 2009

Region IX
Office of Audit Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Report Number: A-09-09-00077

Mr. Toby Douglas
Chief Deputy Director of Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, MS 0002
Sacramento, California 95814

Dear Mr. Douglas:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled “Review of Medicaid Credit Balances at Oroville Hospital as of February 28, 2009.” We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to contact Doug Preussler, Audit Manager, at (415) 437-8360 or through email at Doug.Preussler@oig.hhs.gov, or contact Anthony Rocha, Senior Auditor, at (916) 498-6641, extension 223, or through email at Anthony.Rocha@oig.hhs.gov. Please refer to report number A-09-09-00077 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF
MEDICAID CREDIT BALANCES
AT OROVILLE HOSPITAL
AS OF FEBRUARY 28, 2009**



Daniel R. Levinson
Inspector General

August 2009
A-09-09-00077

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In California, the Department of Health Care Services (the State agency) administers Medicaid.

Credit balances may occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the program payment ceiling or allowable costs, resulting in an overpayment. Credit balances may also occur when a provider receives payments for the same services from the Medicaid program and another third-party payer. In such cases, the provider should return the overpayment to the Medicaid program, which is the payer of last resort.

Section 1903(d)(2)(C) of the Act, implemented at 42 CFR § 433.300(b), states: “. . . when an overpayment is discovered . . . the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. . . . [T]he adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.”

The State agency does not have any regulations requiring providers to refund Medicaid credit balances within a specific timeframe. However, State Medicaid cost report instructions state that it is the provider’s responsibility to maintain an effective system to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments. In addition, providers must report outstanding credit balances as part of their annual cost report submissions and refund any overpayments when the State agency settles the cost reports.

Oroville Hospital (Oroville), part of OroHealth Corporation, is an acute care hospital located in Oroville, California. Oroville reported that it was reimbursed by the State agency approximately \$19.6 million for Medicaid services during calendar year 2008.

OBJECTIVE

Our objective was to determine whether the Medicaid credit balances recorded in Oroville’s accounting records as of February 28, 2009, for inpatient and outpatient services represented overpayments that Oroville should have returned to the Medicaid program.

SUMMARY OF FINDINGS

As of February 28, 2009, Oroville's Medicaid credit balances included 98 overpayments totaling \$51,646 (\$25,908 Federal share) that had not been returned to the Medicaid program. Because we did not review 676 credit balances totaling \$49,527, we cannot express an opinion on this amount. Oroville did not return the majority of overpayments to the State agency because Oroville lacked adequate policies and procedures to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$25,908 (Federal share) in Medicaid overpayments to Oroville and
- work with Oroville to develop adequate policies and procedures to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency agreed with our recommendations. The State agency's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In California, the Department of Health Care Services (the State agency) administers Medicaid.

Credit balances may occur when the reimbursement that a provider receives for services provided to a Medicaid beneficiary exceeds the program payment ceiling or allowable costs, resulting in an overpayment. Credit balances may also occur when a provider receives payments for the same services from the Medicaid program and another third-party payer. In such cases, the provider should return the overpayment to the Medicaid program, which is the payer of last resort.

Federal and State Requirements

Section 1903(d)(2)(C) of the Act, implemented at 42 CFR § 433.300(b), states: “. . . when an overpayment is discovered . . . the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. . . . [T]he adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.”

The State agency does not have any regulations requiring providers to refund Medicaid credit balances within a specific timeframe. However, State Medicaid cost report instructions state that it is the provider's responsibility to maintain an effective system to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments. In addition, providers must report outstanding credit balances as part of their annual cost report submissions and refund any overpayments when the State agency settles the cost reports.

Providers must submit their annual Medicaid cost reports within 150 days after the end of the provider fiscal year. Pursuant to section 14170(a)(1) of the California Welfare and Institutions Code, the State agency has 3 years after the provider's fiscal year or the date of the submission, whichever is later, to audit or review the cost report.

Oroville Hospital

Oroville Hospital (Oroville), part of OroHealth Corporation, is an acute care hospital located in Oroville, California. Oroville reported that it was reimbursed by the State agency approximately \$19.6 million for Medicaid services during calendar year 2008.

Oroville transfers all credit balances, including Medicaid credit balances, to a refunds payable account before refunding any overpayments. After credit balances are transferred into a refunds payable account, they no longer appear on Oroville's credit balances report.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the Medicaid credit balances recorded in Oroville's accounting records as of February 28, 2009, for inpatient and outpatient services represented overpayments that Oroville should have returned to the Medicaid program.

Scope

Oroville's February 28, 2009, credit balances report included 641 Medicaid credit balances totaling \$54,779. Of these credit balances, Oroville identified 119 as overpayments due to Medicaid (totaling \$6,618) and 522 as credit balances not due to Medicaid (totaling \$48,161):

- Of the 119 credit balances that Oroville identified as overpayments due to Medicaid, we reviewed all 70 credit balances over \$20, totaling \$6,127. We did not review the remaining 49 credit balances totaling \$491.
- Of the 522 credit balances that Oroville identified as credit balances not due to Medicaid, we reviewed a judgmental sample of 30 credit balances totaling \$14,959. We did not review the remaining 492 credit balances totaling \$33,202.

In addition, Oroville's accounting records as of February 28, 2009, included 164 Medicaid credit balances, totaling \$139,091, that Oroville identified as Medicaid overpayments and transferred to a refunds payable account; these credit balances did not appear on the February 28, 2009, credit balances report. We reviewed all 29 of these credit balances over \$500, totaling \$123,257. We did not review the remaining 135 credit balances totaling \$15,834.

Our objective did not require an understanding or assessment of the complete internal control system at Oroville. We limited our review of internal controls to obtaining an understanding of the policies and procedures that Oroville used to review credit balances and report overpayments to the State Medicaid program.

We performed our fieldwork at Oroville's business office in Oroville, California, from March through July 2009.

Methodology

To accomplish our objective, we:

- reviewed Federal and State requirements pertaining to Medicaid credit balances and overpayments;
- obtained an understanding of Oroville's policies and procedures for reviewing credit balances and reporting overpayments to the State agency;
- identified Oroville's Medicaid credit balances from its accounting records and reconciled the Medicaid credit balances to Oroville's Medicaid credit balances report as of February 28, 2009;
- compared Oroville's November 28, 2008, credit balances report with its February 28, 2009, credit balances report;
- reconciled Oroville's accounts receivable refunds payable account and its November 28, 2008, credit balances report to the trial balance;
- reviewed Oroville's accounting records for selected credit balances, including patient payment data, Medicaid claim forms and remittance advices, patient accounts receivable detail, and additional supporting documentation;
- calculated the Federal share of overpayments based on the Federal medical assistance percentage effective on the date the overpayment occurred; and
- coordinated our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

As of February 28, 2009, Oroville's Medicaid credit balances included 98 overpayments totaling \$51,646 (\$25,908 Federal share) that had not been returned to the Medicaid program. Because we did not review 676 credit balances totaling \$49,527, we cannot express an opinion on this amount.

OUTSTANDING CREDIT BALANCES WITH MEDICAID OVERPAYMENTS

As of February 28, 2009, Oroville's Medicaid credit balances included 98 overpayments totaling \$51,646 (\$25,908 Federal share) that had not been returned to the Medicaid program. The ages of the 98 overpayments ranged from 1 day to over 730 days, as the following table summarizes.

Ages of Overpayments as of February 28, 2009

Days	No. of Credit Balances	Overpayment Amount	Federal Share
1–60	38	\$2,447	\$1,223
61–180	17	25,442	12,721
181–365	18	5,856	2,929
366–730	5	1,840	920
> 730	20	16,061	8,115
Total	98	\$51,646	\$25,908

The 98 overpayments consisted of the following:

- Of the 70 credit balances over \$20 that Oroville identified as overpayments due to Medicaid, 68 credit balances totaling \$5,942 (\$2,975 Federal share) represented overpayments due to Medicaid.
- Of the 30 credit balances in our judgmental sample that Oroville identified as credit balances not due to Medicaid, four credit balances totaling \$683 (\$358 Federal share) represented overpayments due to Medicaid.
- Of the 29 credit balances over \$500 that Oroville identified as overpayments due to Medicaid and transferred to a refunds payable account, 26 credit balances totaling \$45,021 (\$22,575 Federal share) represented overpayments due to Medicaid.

Oroville did not return the majority of overpayments to the State agency because Oroville lacked adequate policies and procedures to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments.

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government \$25,908 (Federal share) in Medicaid overpayments to Oroville and
- work with Oroville to develop adequate policies and procedures to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments.

STATE AGENCY COMMENTS

In its comments on our draft report, the State agency agreed with our recommendations. The State agency's comments are included in their entirety as the Appendix.

APPENDIX



DAVID MAXWELL-JOLLY
Director

State of California—Health and Human Services Agency
Department of Health Care Services



ARNOLD SCHWARZENEGGER
Governor

AUG 19 2009

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
90 7th Street, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand:

The California Department of Health Care Services (DHCS) has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled "Review of Medicaid Credit Balances at Oroville Hospital as of February 28, 2009" (A-09-09-00077). DHCS appreciates the work performed by the OIG and the opportunity to respond to the draft report.

Please contact Ms. Traci Walter, Audit Coordinator, at (916) 650-0298 if you have any questions.

Sincerely,

Toby Douglas
Chief Deputy Director
Health Care Programs

cc: See next page

Ms. Lori A. Ahlstrand
Page 2

AUG 19 2009

cc: Ms. Karen Johnson
Chief Deputy Director
Policy and Program Support
1501 Capitol Avenue, MS 0005
P.O. Box 997413
Sacramento, CA 95899-7413

Ms. Jan English
Acting Deputy Director
Audits and Investigations Division
1501 Capitol Avenue, MS 2000
P.O. Box 997413
Sacramento, CA 95899-7413

Mr. Bill Alameda, Chief
Financial Audits Branch
Audits and Investigations Division
1501 Capitol Avenue, MS 2100
P.O. Box 997413
Sacramento, CA 95899-7413

**Department of Health Care Services
Response to the Office of Inspector General's Draft Report Entitled**

***Review of Medicaid Credit Balances at
Oroville Hospital as of February 28, 2009***

Recommendation: We recommend that the State agency refund to the Federal Government \$25,908 (Federal share) in Medicaid overpayments to Oroville.

Response: The Department of Health Care Services (DHCS) agrees with the recommendation and will issue a demand letter to Oroville Hospital to refund the amount of \$51,646. An accounts receivable will be established and the \$25,908 will be returned to the Federal Government.

Recommendation: We recommend that the State agency work with Oroville to develop adequate policies and procedures to prevent, detect in a timely fashion, and take proper corrective action for Medicaid overpayments.

Response: The DHCS Financial Audits Branch (FAB) conducts annual Medi-Cal cost report audits of all acute care facilities. These audits include steps to review for credit balances. The audit of future cost reports for Oroville Hospital will include a review for credit balances. FAB will work with Oroville Hospital during these audits to assure that adequate policies and procedures are developed.